EXHIBIT C



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

ALBANY NY 12203-4474

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

This Form is Open to Public Inspection

813930

the instructions to the Form 5500. Part I Annual Report Identification Information For the calendar plan year 2008 or fiscal plan year beginning May 01, 2008 , and ending April 30, 2009 A This return/report is (1) X a multiemployer plan; (3) a multiple-employer plan; for: (2) a single-employer plan (other than a multiple-(4) a DFE (specify) employer plan); B This return/report is: (1) ☐ the first return/report filed for the plan; (3) the final return/report filed for the plan; (4) a short plan year return/report (less than 12 (2) the amended return/report; C If the plan is a collectively-bargained plan, check here D If you filed for an extension of time to file, check the box and attach a copy of the extension application 🗵 Part II - Basic Plan Information - enter all requested information. 1a Name of plan 1b Three-digit 002 plan number (PN) BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND 1c Effective date of plan (mo., day, yr.) July 01, 1987 2a Plan sponsor's name and address (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) 16-1298070 (Address should include room or suite no.) 2c Sponsor's telephone number BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND 518-456-0259 · 2d Business code (see instructions) 300 CENTRE DRIVE

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	11/26/1202	STEVEN J OSICK,	PLAN ADMINI	STRATOR
Signature of plan administrator	Date	Typed or printed name of ind	ividual signing	as plan administrator
		BRICKLAYERS & A	LLIED CRAFT	WORKERS
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of ir sponsor or	ndividual signing D F E as applica	
For Paperwork Reduction Act Notice and OMB Co v11.3	ntrol Numbers,	see the instructions for Form	n 5500.	Form 5500 (2008)
3a Plan administrator's name and address (if same as	plan sponsor, e	enter"Same")	3b Administrat	
SA14H		· ·	3c Administrat	tor's telephone number
If the name and/or EIN of the plan sponsor has char name, EIN and the plan number from the last return.		st return/report filed for this pla	an, enter the	b EIN
a Sponsor's name	report below.			c PN

Instant 01-789 regree 1990 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit \mathcal{C}_{2} of 2 Objectors Form 5500s Pg 3 of 43

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN 14-1624930
TRAL, BECKKK & CHIARAM014TE CPAS PC 7 WAAHINGTON SQUARLR AT-BANY 12205	c Telephone no. 518-456-6663
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	1263
a Active participants	1455
b Retired or separated participants receiving benefits	
c Other retired or separated participants entitled to future benefits	;
d Subtotal. Add lines 7a , 7b , and 7c	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	
f Total. Add lines 7d and 7e	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	
 h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested 	
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)	
a <u>Nension benefits</u> (check this box if the plan provides pension benefits and enter the applicable pension feature of Plan Characteristics Codes (printed in the instructions)):	codes from the List
2C 3B	
_	
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature of Plan Characteristics Codes (printed in the instructions)):	codes from the List of
That officialities obdes (printed in the instructions)).	
9a Plan funding arrangement (check all that apply) (1) ☐ Insurance 9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance	
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts	
(3) Trust	
(4) General assets of the sponsor (4) General assets of the sponsor	
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruction	s.)
a Pension Benefit Schedules b Financial Schedules	
(1) X R (Retirement Plan Information) (1) X H (Financial Information)	
(2) I (Financial Information – Small Plan) (2) OT (Qualified Pension Plan Coverage Information) (3) I A (Insurance Information)	
(4) X C (Service Provider Information)	
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (6) D (DFE/Participating Plan Information) G (Financial Transaction Schedules)	
year, enter the year	
(3) B (Actuarial Information) (4) E (ESOP Annual Information)	
(5) SSA (Separated Vested participant Information)	



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to Public Inspection

		Complete al	l entries in accordictions to the For	dance with		
	Identification Information ar 2008 or fiscal plan year	beginning Ma	v 01, 2008 , and	endina April	30. 2009	
A This return/report is for:	(1) X a multiemployer plar (2) ☐ a single-employer planemployer plan);	;			iple-employer plan	;
B This return/report is:	(1) the first return/report (2) the amended return/		an;		al return/report filed t plan year return/r	
C If the plan is a collective	ely-bargained plan, check he	re 🗓		,		
D If you filed for an extens	sion of time to file, check the	box and attac	h a copy of the ex	tension applic	cation 🗵	
	ormation - enter all requeste	ed information				
1a Name of plan				1b	Three-digit plan number (PN)	501
BRICKLAYERS & ALLI	ED CRAFTWORKERS L AL	BANY, NY HE	ALTH BENEFIT F	UND 1c	Effective date of p November 15, 196	lan (mo., day, yr.)
2a Plan sponsor's name ar (Address should include	nd address (employer, if for a e room or suite no.)	a single-emplo	yer plan)	2b	Employer Identification 14-1461803	ation Number (EIN)
BRICKLAYERS & ALLI	ED CRAFTWORKERS L2 A	IRANY NY H	FAI TH BENEFIT	ELIND 2c	Sponsor's telepho 518-456-0259	ne number
300 CENTRE DRIVE ALBANY NY 12203-447			E/KEIII BEIKEI II		Business code (se 813930	e instructions)
Under penalties of perjury	late or incomplete filing of the and other penalties set forth statements and attachments	in the instruct	ions, I declare that est of my knowledo	t I have exam ge and belief,	ined this return/rep	ort, including nd complete.
Signature of p	lan administrator	Date	Typed or printed	d name of ind	ividual signing as p	lan administrator
			BRICK	(LAYERS & A	LLIED CRAFTWO	RKERS
Signature of employ	yer/plan sponsor/D F E	Date	Typed or print		dividual signing as DFE as applicable	employer, plan
For Paperwork Reduction v11.3	Act Notice and OMB Con	trol Numbers	, see the instruct	ions for Forr	n 5500.	Form 5500 (2008)
3a Plan administrator's nar	ne and address (if same as	olan sponsor,	enter"Same")		3b Administrator's	
SAME					3c Administrator's	telephone number
	the plan sponsor has chang number from the last return/r		ast return/report fil	led for this pla	an, enter the	b EIN
a Sponsor's name						c PN

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5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN 14-1624930
TEAL, BECKER & CHIARAMONTE CPAS PC 7 WASHINGTON SQUARE ALBANY NY 12205	c Telephone no. 518-456-6663
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 · 666
a Active participants	a 664
b Retired or separated participants receiving benefits	· b · 18
c Other retired or separated participants entitled to future benefits	C (O
d Subtotal. Add lines 7a, 7b, and 7c	d 682
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	е
f Total. Add lines 7d and 7e	f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i
8 Benefits provided under the plan (complete 8a through 8c, as applicable)	
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension fea of Plan Characteristics Codes (printed in the instructions)):	ure codes from the List
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature)	re codes from the List of
Plan Characteristics Codes (printed in the instructions)):	
<u>4A 4B 4C 4D 4E 4I</u>	<u> 4Q</u>
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (1) ☐ Insurance	
(2) Section 412(e)(3) insurance contracts (3) Trust (2) Section 412(e)(3) insurance contracts (3) Trust	
(4) General assets of the sponsor (4) General assets of the sponsor	
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruct	ions.)
a Pension Benefit Schedules b Financial Schedules	,
(1) R (Retirement Plan Information) (1) H (Financial Information)	
(2) [I] (Financial Information – Small P	an)
(2) ☐0T (Qualified Pension Plan Coverage Information) (3) ☒ 10 A (Insurance Information) (4) ☒ C (Service Provider Information)	
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (5) D (DFE/Participating Plan Information G (Financial Transaction Schedule	
(3) B (Actuarial Information)	



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

6563 RIDINGS ROAD

SYRACUSE NY 13206-1202

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

This Form is Open to Public Inspection

· 2d Business code (see instructions)

525100

the instructions to the Form 5500. Part I Annual Report Identification Information For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009 A This return/report is (1) a multiemployer plan; (3) X a multiple-employer plan; for: (2) a single-employer plan (other than a multiple-(4) a DFE (specify) employer plan); B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan; (4) \square a short plan year return/report (less than 12 (2) the amended return/report; C If the plan is a collectively-bargained plan, check here \square D If you filed for an extension of time to file, check the box and attach a copy of the extension application 🗵 Part II Basic Plan Information - enter all requested information. 1a Name of plan 1b Three-digit 501 plan number (PN) BUILDING TRADES EMPLOYERS INSURANCE FUND HEALTH PL · 1c Effective date of plan (mo., day, yr.) July 01, 1965 2a Plan sponsor's name and address (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) (Address should include room or suite no.) 22-3089633 2c Sponsor's telephone number BUILDING TRADES EMPLOYERS INSURANCE 315-437-9284

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

		EARL N. HALL			
Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator			
		EARL N. HALL			
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signi sponsor or DFE as applic			
For Paperwork Reduction Act Notice and OMB Con v11.3	trol Number	s, see the instructions for Form 5500.	Form 5500 (2008)		
3a Plan administrator's name and address (if same as SAME	plan sponsor,		ator's EIN ator's telephone number		
4 If the name and/or EIN of the plan sponsor has chang name, EIN and the plan number from the last return/r		last return/report filed for this plan, enter the	b EIN		
a Sponsor's name			c PN		

Instant 01789 regree 1990 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit \bigcirc of 2 Objectors Form 5500s Pg 7 of 43

5 Preparer information (optional) a Name (including firm name, if applicable) and address J BRADFORD MANN 7030 E GENESEE STREET	b EIN 16-1143867 c Telephone no. 315-446-5745	
FAYETTEVILLE 13066-1126 6 Total number of participants at the beginning of the plan year 7 New to a static participant and of the plan year (voltage plans appears and the plan year)	· 6 · 946	
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a , 7b , 7c , and 7d) a Active participants	a 1575	
b Retired or separated participants receiving benefits	· b · 34	
c Other retired or separated participants entitled to future benefits	C	
d Subtotal. Add lines 7a, 7b, and 7c	d 1609	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	е	
f Total. Add lines 7d and 7e	f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)		
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension fear of Plan Characteristics Codes (printed in the instructions)):	ature codes from the List	t
(F		
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature. Plan Characteristics Codes (printed in the instructions)): 4A 4B	ure codes from the List o	of
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)		
(1) Insurance (1) Insurance		
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
(3) Trust (3) Trust		
(4) ☐ General assets of the sponsor (4) ☐ General assets of the sponsor 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.	ctions)	
a Pension Benefit Schedules boxes and, where indicated, enter the number attached. See instruc-	Alloris.)	
(1) R (Retirement Plan Information) (1) X H (Financial Information)		
(2) 🔲 I (Financial Information – Small Pl	lan)	
(2) ☐0T (Qualified Pension Plan Coverage Information) (3) ☒ 0 A (Insurance Information) (4) ☒ C (Service Provider Information)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year		
(3) B (Actuarial Information)		
(4) E (ESOP Annual Information)		
(5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to **Public Inspection**

			l entries in accord		
	Identification Information	Lanianian to	h- 04 2000d	di b 20 2000	
•	ar 2008 or fiscal plan year		iy 01, 2008 , and (
A This return/report is for:	 (1) ∑ a multiemployer plan (2) ☐ a single-employer plan); 		a multiple-	(3) ☐ a multiple-employer p (4) ☐ a DFE (specify)	lan;
B This return/report is:	(1) the first return/report (2) the amended return/		lan;	(3) ☐ the final return/report (4) ☐ a short plan year retumonths).	
C If the plan is a collective	ely-bargained plan, check he	ere 🛚		····-/	
•	sion of time to file, check the		ch a copy of the ex	tension application \square	
Part II Basic Plan Inf	ormation - enter all request	ed information	L.		
1a Name of plan ONONDAGA COUNTY	LABORERS ANNUITY FU	ND		1b Three-digit plan number (legan number (legan number (legan April 01, 1984)	PN) 002 of plan (mo., day, yr.)
2a Plan sponsor's name a (Address should includ	nd address (employer, if for e room or suite no.)	a single-emplo	oyer plan)	16-1229376	tification Number (EIN)
ONONDAGA COUNTY	LABORERS ANNUITY FU	ND BOARD OF	F TRUSTEES	2c Sponsor's tele 315-434-9305	onone number
7051 FLY ROAD EAST SYRACUSE NY				2d Business code 525100	(see instructions)
Under penalties of perjury	and other penalties set forth	in the instruct	tions, I declare that	unless reasonable cause is t I have examined this return ge and belief, it is true, correc	report, including
				GABRIEL ROSETTI, III	
Signature of p	lan administrator	Date	Typed or printed	d name of individual signing	as plan administrator
				EARL R. HALL	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or print	ed name of individual signing sponsor or DFE as applica	
For Paperwork Reduction v11.3	n Act Notice and OMB Cor	ntrol Numbers	s, see the instruct	ions for Form 5500.	Form 5500 (2008)
	me and address (if same as	plan sponsor,	enter"Same")	3b Administra	
SAME				. SC Administra	tor's telephone number
	f the plan sponsor has chan number from the last return/		last return/report fi	led for this plan, enter the	b EIN
a Sponsor's name		-			c PN

Install 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibite of 2 Objectors Form 5500s Pg 9 of 43

5 F	Preparer information (optional) a Name (including firm name, if applicable) and address	ŀ	EIN 16-1537589
2	RICHARD W. HEIMERMAN, CPA P.C. 90 ELWOOD DAVIS ROAD, SUITE 280 IVERPOOL NY 13088-0000	· c	Telephone no. 315-451-9771
6	Total number of participants at the beginning of the plan year	· 6 ·	492
	Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		***
	Active participants	a	529
	Retired or separated participants receiving benefits	· p ·	19
	Other retired or separated participants entitled to future benefits	c d	285 8 33
	Subtotal. Add lines 7a, 7b, and 7c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	u e	033 19
	Fotal. Add lines 7d and 7e	f	852
g l	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	852
h l	Number of participants that terminated employment during the plan year with accrued benefits that were less han 100% vested	h	
i I	f any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i	17
	Benefits provided under the plan (complete 8a through 8c, as applicable)		
	☑ <u>Pension benefits</u> (check this box if the plan provides pension benefits and enter the applicable pension featu of Plan Characteristics Codes (printed in the instructions)):	ure co	odes from the List
	<u>2E</u>		
	_	-	
	☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature	e cod	es from the List of
ľ	Plan Characteristics Codes (printed in the instructions)):		
		_	
	Plan funding arrangement (check all that apply) (1) Insurance 9b Plan benefit arrangement (check all that apply) (1) Insurance		
	(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
	(3) Trust (3) Trust		
	(4) General assets of the sponsor (4) General assets of the sponsor		
	Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruction	ons)	
	Pension Benefit Schedules b Financial Schedules	o,	
	1) R (Retirement Plan Information) (1) X H (Financial Information)		
	(2) I (Financial Information – Small Pla	n)	
(2) 0T (Qualified Pension Plan Coverage Information) (3) 1 A (Insurance Information) (4) 1 C (Service Provider Information)		
	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year		
- (·	3) B (Actuarial Information) 4) E (ESOP Annual Information) 5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

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Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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			uctions to the Fo		
	Identification Information				
•	ar 2008 or fiscal plan year		ily 01, 2008 , and		
A This return/report is for:	 (1)		a multiple-	(3) ☐ a multiple-employer pl (4) ☐ a DFE (specify)	an;
B This return/report is:	(1) the first return/report (2) the amended return/		lan;	(3) the final return/report f (4) a short plan year retur months).	
C If the plan is a collectiv	ely-bargained plan, check he	ere 🛚		monaloj.	
D If you filed for an exten	sion of time to file, check the	box and attac	ch a copy of the e	extension application 🗵	
•	ormation – enter all request	ed informatior	۱.		
1a Name of plan				1b Three-digit	501
CENTRAL NEW YORK	(LABORERS WELFARE FL	IND		plan number (P 1c Effective date o May 21, 1953	
2a Plan sponsor's name a (Address should includ	nd address (employer, if for e room or suite no.)	a single-emplo	oyer plan)	. 16-6044095	fication Number (EIN)
CENTRAL NEW YORK	(LABORERS WELFARE FU	ND BOARD (OF TRUSTEES	2c Sponsor's telep 315-434-9305	hone number
7051 FLY ROAD EAST SYRACUSE NY	13057-9659			2d Business code 525100	(see instructions)
Under penalties of perjury	and other penalties set forth	in the instruc	tions, I declare th	ed unless reasonable cause is e lat I have examined this return/r ladge and belief, it is true, correct	eport, including
				GABRIEL ROSETTI, III	
Signature of p	lan administrator	Date	Typed or print	ted name of individual signing a	s plan administrator
				EARL R. HALL	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or pri	nted name of individual signing sponsor or DFE as applicab	
For Paperwork Reduction v11.3	n Act Notice and OMB Con	trol Numbers	s, see the instru	ctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's na	me and address (if same as	plan sponsor,	enter"Same")	3b Administrato	
SAME				3c Administrato	or's telephone number
4 If the name and/or EIN o	f the plan sponsor has chang	ged since the	last return/report	filed for this plan, enter the	b EIN
a Sponsor's name	number from the last return/r	ероп реюм.			c PN
a oponisor s name					

Instant 08-01-789 regree 1990 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit C_2 of 2 Objectors Form 5500s Pg 11 of 43

5	Preparer information (optional) a Name (including firm name, if applicable) and address		b EIN 16-1537589
	RICHARD W. HEIMERMAN, CPA P.C. 290 ELWOOD DAVIS ROAD, SUITE 280 LIVERPOOL NY 13088-0000	-	c Telephone no. 315-451-9771
6		· 6 ·	635
	Active participants	а	288
	, ,	b ·	250
	Other retired or separated participants entitled to future benefits	С	173
	Subtotal. Add lines 7a, 7b, and 7c	d	711
	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	e	
	Total. Add lines 7d and 7e Number of participants with account balances as of the end of the plan year (only defined contribution plans	f	
_	complete this item)	g	
	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i	
	Benefits provided under the plan (complete 8a through 8c, as applicable)		
а	Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature of Plan Characteristics Codes (printed in the instructions)):	ure o	codes from the List
	or Plan Characteristics Codes (printed in the instructions)).		
b	Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature	е со	des from the List of
	Plan Characteristics Codes (printed in the instructions)):		
	<u>4A 4D 4E 4F 4L</u>		
9a	Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)		
	(1) Insurance (1) Insurance		
	(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
	(3) ☐ Trust (4) ☐ General assets of the sponsor (4) ☐ General assets of the sponsor		
10	(4) ☐ General assets of the sponsor (4) ☐ General assets of the sponsor Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruction	nne	١
	Pension Benefit Schedules b Financial Schedules	JI 13.	,
	(1) R (Retirement Plan Information) (1) H (Financial Information)		
	(2) I (Financial Information – Small Plan	n)	
	(2) ☐0T (Qualified Pension Plan Coverage Information) (3) 🛣 1 A (Insurance Information) (4) 🛣 C (Service Provider Information)		
	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (4) (C (Service Provider Information) (D (DFE/Participating Plan Information) (G) (G) (G) (G) (Financial Transaction Schedules)		
	(3) B (Actuarial Information) (4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

		uie insui	icuons to the ro	m 5500.	
•	t Identification Information ear 2008 or fiscal plan year		lly 01, 2008 , and	ending June 30, 2009	
A This return/report is for:	(1) ☑ a multiemployer pla (2) ☐ a single-employer p employer plan);		a multiple-	(3) ☐ a multiple-employer plan;(4) ☐ a DFE (specify)	
B This return/report is:	(1) ☐ the first return/repor (2) ☐ the amended return.		lan;	(3) ☐ the final return/report filed for (4) ☐ a short plan year return/report months).	
C If the plan is a collective	ely-bargained plan, check h	ere 🗓			
	sion of time to file, check the		• •	rtension application $f ar{X}$	
Part II Basic Plan Inf 1a Name of plan	ormation – enter all request	ted information		1b Three-digit	
,	KLABORERS PENSION FU	ND		plan number (PN) 1c Effective date of plar January 05, 1960	001 ı (mo., day, yr.)
2a Plan sponsor's name a (Address should include	and address (employer, if for le room or suite no.)	a single-emplo	oyer plan)	2b Employer Identification 15-6016579	
CENTRAL NEW YORK 7051 FLY ROAD EAST SYRACUSE NY	CLABORERS PENSION FU 13057-9659	ND BOARD O	F TRUSTEES	 2c Sponsor's telephone 315-434-9305 2d Business code (see i 525100 	
Under penalties of perjury	and other penalties set forth	in the instruct	ions, I declare tha	d unless reasonable cause is establi t I have examined this return/report ge and belief, it is true, correct, and	including
				GABRIEL M. ROSETTI, III	
Signature of p	olan administrator	Date	Typed or printe	d name of individual signing as plar	administrator
				EARL R. HALL	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or prin	ted name of individual signing as en sponsor or DFE as applicable	nployer, plan
For Paperwork Reductio v11.3	n Act Notice and OMB Cor	ntrol Numbers	s, see the instruc	tions for Form 5500.	orm 5500 (2008)
	me and address (if same as	plan sponsor,	enter"Same")	3b Administrator's El	
SAME				3c Administrator's te	lephone number
	of the plan sponsor has chan number from the last return/		last return/report f	iled for this plan, enter the b	EIN
a Sponsor's name	212 323 33410	1		c	PN

Instable 12.43:49 FGGERIDAC 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibite $Q_{of 2}$ Objectors Form 5500s Pg 13 of 43

5	Preparer information (optional) a Name (including firm name, if applicable) and address	t	EIN 16-1537589
	RICHARD W. HEIMERMAN, CPA P.C. 290 ELWOOD DAVIS ROAD, SUITE 280 LIVERPOOL NY 13088-0000	· c	Telephone no. 315-451-9771
6	Total number of participants at the beginning of the plan year	· 6 ·	677
	Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		0.40
	Active participants	a	219
	Retired or separated participants receiving benefits	· b ·	281
	Other retired or separated participants entitled to future benefits	C.	100
	Subtotal. Add lines 7a, 7b, and 7c	d	600
	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits Total. Add lines 7d and 7e	e f	74 674
			0/4
_	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i	7
	Benefits provided under the plan (complete 8a through 8c, as applicable)		
а	Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat of Plan Characteristics Codes (printed in the instructions)):	ure co	odes from the List
	· · · · · · · · · · · · · · · · · · ·		
	<u>1B</u> 1G	-	
b	Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature	e cod	es from the List o
	Plan Characteristics Codes (printed in the instructions)):		
_		-	
ча	Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)		
	(1) Insurance (1) Insurance		
	(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
	(3) Trust		
	(4) General assets of the sponsor (4) General assets of the sponsor		
10	Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructi	ons.)	
	Pension Benefit Schedules (1) R (Retirement Plan Information) b Financial Schedules (1) H (Financial Information)		
	(1) X R (Retirement Plan Information) (1) X H (Financial Information) (2) I (Financial Information – Small Pla	n)	
	(2) OT (Qualified Pension Plan Coverage Information) (3) O A (Insurance Information)	'''	
	(4) X C (Service Provider Information) If a Schedule T is not attached because the plan is (5) X D (DFE/Participating Plan Informatic	on)	
	relying on coverage testing information for a prior (6) G (Financial Transaction Schedules)		
	year, enter the year		
	(3) B (Actuarial Information) (4) E (ESOP Annual Information)		
	(5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to **Public Inspection**

Complete all entries in accordance with the instructions to the Form 5500.

for: (2) a single-employer plan (other than a multiple-employer plan): B This return/report is: (1) the first return/report filed for the plan; (2) the amended return/report; (4) a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check here mended return/report; (4) a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check here months. C If the plan is a collectively-bargained plan, check the plan is a short plan intermore point (less than 12 months). C If the plan is a collectively-bargained plan, check the plan is a short plan intermore plan (less than 12 months). C If the plan is a collectively-bargained plan, check the plan is a short plan intermore plan (less than 12 months). C If the plan is a collective date of plan intermore plan (less than 12	·	or fiscal plan year beginning April 01, a multiemployer plan;	(3) ☐ a multiple-employer plan;	
C If the plan is a collectively-bargained plan, check here D If you filed for an extension of time to file, check the box and attach a copy of the extension application Part II Basic Plan Information – enter all requested information. 1a Name of plan ENGINEERS JOINT WELFARE FUND LOCAL UNIONS 17,106,410,463,545,832 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) BD OF TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE PO BOX 100 COLVIN STA SYRACUSE NY 13205-0100 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. O1/01/2210 THERON HOQLE Signature of plan administrator Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008 SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the beIN arms. EIN and the plan number from the last return/report below:	for: (2)	a single-employer plan (other than a multi		
D if you filed for an extension of time to file, check the box and attach a copy of the extension application Part II Basic Plan Information – enter all requested information. 1a Name of plan ENGINEERS JOINT WELFARE FUND LOCAL UNIONS 17,106,410,463,545,832 1c Effective date of plan (mo., day, yr.) January 05, 1957 2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) BD OF TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE PO BOX 100 COLVIN STA SYRACUSE NY 13205-0100 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. O1/01/2210 THERON HOQLE Signature of plan administrator Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008 Administrator's name and address (if same as plan sponsor, enter "Same") SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the b EIN and the plan number from the last return/report below:			(4) a short plan year return/report (less that	
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18 Name of plan ENGINEERS JOINT WELFARE FUND LOCAL UNIONS 17,106,410,463,545,832 29 Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) BD OF TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE PO BOX 100 COLVIN STA SYRACUSE NY 13205-0100 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. O1/01/2210 THERON HOQLE Signature of plan administrator Date Typed or printed name of individual signing as plan administrator 11/01/2210 EUQENE P. HALLOCK Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the BIO TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE 15-0582931 2c Sponsor's telephone number 3-15-0582931 2c Sponsor's telephone number 3-16-492-1736 2d Business code (see instructions) 525100 THERON HOQLE Signature of plan administrator 11/01/2210 THERON HOQLE Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008) 3b Administrator's telephone number 3ch Administrator's telephone number 3ch Administrator's telephone number 3ch Administrator's telephone number 3ch Administrator's telephone number form the last return/report filed for this plan, enter the		•	by of the extension application \square	
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2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) BD OF TRUSTEES ENG JT WELF FD LCL UNIONS 17,106,410,463,545,832 IUOE PO BOX 100 COLVIN STA SYRACUSE NY 13205-0100 Caution: A penalty for the late or incomplete filling of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. O1/01/2210 THERON HOQLE Signature of plan administrator Date Typed or printed name of individual signing as plan administrator 11/01/2210 EUQENE P. HALLOCK Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008) 3a Plan administrator's name and address (if same as plan sponsor, enter "Same") SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the b EIN b EIN	•		plan number (PN)	1
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PO BOX 100 COLVIN STA SYRACUSE NY 13205-0100 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. O1/01/2210 THERON HOQLE Signature of plan administrator Date Typed or printed name of individual signing as plan administrator 11/01/2210 EUQENE P. HALLOCK Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008 13 Administrator's EIN SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the ab EIN name, EIN and the plan number from the last return/report below:	BD OF TRUSTEES ENG JT V	VELF FD LCL UNIONS 17,106,410,463,54		
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a Sponsor's name	Under penalties of perjury and oth accompanying schedules, statem Signature of plan add Same and Same and Same	ner penalties set forth in the instructions, I ents and attachments, and to the best of notice and OMB Control Numbers, see to address (if same as plan sponsor, enter"S an sponsor has changed since the last reto	declare that I have examined this return/report, including my knowledge and belief, it is true, correct, and complete. THERON HOQLE ed or printed name of individual signing as plan administrated by the sponsor or DFE as applicable as applicable as applicable be instructions for Form 5500. Same") 3b Administrator's EIN 3c Administrator's telephone numbers.	an 2008)

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN 13-1577780
SCHULTHEIS & PANETTIERI, LLP 210 MARCUS BOULEVARD HAUPPAUGE NY 11788-3740	c Telephone no. 631-273-4778
6 Total number of participants at the beginning of the plan year	· 6 · 3995
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	
a Active participants	a 2479
b Retired or separated participants receiving benefits	· b · 1084
c Other retired or separated participants entitled to future benefits	C 2502
d Subtotal. Add lines 7a, 7b, and 7c	d 3563 e
 e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total, Add lines 7d and 7e 	f
g Number of participants with account balances as of the end of the plan year (only defined contribution plans	g
complete this item)	L
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated	i
participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable)	
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat	ure codes from the List
of Plan Characteristics Codes (printed in the instructions)):	are codes from the Elst
u //	
. 📼	dad last last ann
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature)	e codes from the List of
Plan Characteristics Codes (printed in the instructions)):	
<u>4A 4D 4H 4L 4Q 4L</u>	
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)	
(1) ☐ Insurance (1) ☐ Insurance (2) ☐ Option 440(√2) insurance	
(2) ☐ Section 412(e)(3) insurance contracts (3) ☐ Trust (2) ☐ Section 412(e)(3) insurance contracts (3) ☐ Trust	
(4) General assets of the sponsor (4) General assets of the sponsor	
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruction	ions)
a Pension Benefit Schedules b Financial Schedules	0110.7
(1) R (Retirement Plan Information) (1) X H (Financial Information)	
(2) I (Financial Information – Small Pl	an)
(2) ☐0T (Qualified Pension Plan Coverage Information) (3) ☒ 10 A (Insurance Information) (4) ☒ C (Service Provider Information)	
If a Schedule T is not attached because the plan is (5) 🗵 D (DFE/Participating Plan Informati	
relying on coverage testing information for a prior (6) G (Financial Transaction Schedules year, enter the year	š)
(3) B (Actuarial Information)	
(4) E (ESOP Annual Information)	
(5) SSA (Separated Vested participant Information)	



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to **Public Inspection**

			II entries in acc uctions to the F		
	Identification Information				
•	ar 2008 or fiscal plan year		ily 01, 2008 , ar		
A This return/report is for:	 (1)		a multiple-	(3)	an;
B This return/report is:	(1) the first return/report (2) the amended return.		lan;	(3) ☐ the final return/report fi (4) ☐ a short plan year return months).	
C If the plan is a collective	ely-bargained plan, check h	ere X		······································	
D If you filed for an extension Part II Basic Plan Info	sion of time to file, check the	e box and attac			
1a Name of plan				1b Three-digit plan number (Pi	u) 001
IBEW LOCAL 43 & ELI	ECTRICAL CONTRACTOR:	S PENSION F	UND	1c Effective date of July 01, 1962	
2a Plan sponsor's name a (Address should include	nd address (employer, if for e room or suite no.)	a single-emplo	oyer plan)	. 16-6153389	ication Number (EIN)
IBEW LOCAL 43 & ELE	ECTRICAL CONTRACTORS	S PENSION F	JND	2c Sponsor's teleph 315-474-5729	none number
PO BOX 2218 SYRACUSE NY 13220				2d Business code (238210	see instructions)
Under penalties of perjury accompanying schedules,	and other penalties set forth	in the instruc	tions, I declare t est of my knowl	sed unless reasonable cause is enter that I have examined this return/re edge and belief, it is true, correct attended that I have existed name of individual signing as	eport, including and complete.
				HILLIPLLYP P .1"PEU);50^'K	,,C
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or pr	rinted name of individual signing a sponsor or DFE as applicable	
For Paperwork Reduction	n Act Notice and OMB Cor	ntrol Numbers	s, see the instru	uctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's nar	me and address (if same as	plan sponsor,	enter"Same")	3b Administrato	r's EIN
SAME				16-6153389 3c Administrato	r's telephone number
			last return/repor	t filed for this plan, enter the	- b EIN
a Sponsor's name	number from the last return/	report below:			c PN

Instant 01-789 regree 1990 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit Q_{0} of 2 Objectors Form 5500s Pg 17 of 43

PARENTEBEARD LT.C THOMAS E. RILEY 115 SOLAR ST 100 SYRACUSE N 13204 6 Total number of participants at the beginning of the plan year 6 Total number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) a Active participants be Retired or separated participants receiving benefits be Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits by 478 c Other retired or separated participants entitled to future benefits c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits e B6 for Total. Add lines 7a, 7b, 7d, and 7c Deceased participants whose beneficiaries are receiving or are entitled to receive benefits e B6 for Total. Add lines 7a, 7b, 7d, and 7c plans of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less h 14 than 100% vested if any participants sequired to be reported on a Schedule SSA (Form 5500) Benefits provided under the plan (complete 8a through 8c, as applicable) a EQ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)): b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)): b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)): b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)): 19 A Plan funding arrangement (check all	5 Preparer information (optional) a Name (including firm name, if applicable) and address		b EIN 23-2932984
6 1601 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) 8 Active participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) 8 Active participants 9 Retired or separated participants receiving benefits 9 Cother retired or separated participants entitled to future benefits 9 Cother retired or separated participants entitled to future benefits 9 Cother retired or separated participants whose beneficiaries are receiving or are entitled to receive benefits 9 Cother participants whose beneficiaries are receiving or are entitled to receive benefits 9 Cother participants whose beneficiaries are receiving or are entitled to receive benefits 1 Total. Add lines 7d and 7e 1 Total. Add lines 7d and 7e 1 Total. Add lines 7d and 7e 1 Number of participants with account balances as of the end of the plan year (only defined contribution plans 1 Complete this item) 1 Number of participants with account balances as of the end of the plan year with accrued benefits that were less 1 If any participants (s) separated from service with a deferred vested benefit, enter the number of separated 2 If any participants required to be reported on a Schedule SSA (Form 5500) 2 Benefits provided under the plan (complete 8a through 8c, as applicable) 2 Menticipant(s) separated from service with a deferred vested benefit, enter the number of separated 2 If any participants required to be reported on a Schedule SSA (Form 5500) 3 Benefits provided under the plan (complete 8a through 8c, as applicable) 4 Melfare benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)): 9 Plan benefit sense benefits (check all that apply) (1) Insurance (2) Section 412(e)(3) insurance contracts (3) Trust (4) General assets of the sponsor (4) General assets of the sponsor (5) Medicine participants (check all that applicable boxes and, where	115 SOLAR ST 100	•	c Telephone no.
a Active participants b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits c Other retired or separated participants entitled to future benefits c Other retired or separated participants with account balances are receiving or are entitled to receive benefits d Subtotal. Add lines 7d and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits e Passage participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants with account balances as of the end of the plan year with accrued benefits that were less than 100% vested if any participants required to be reported on a Schedule SSA (Form 5500) Benefits provided under the plan (complete 8a through 8c, as applicable) a ⊠ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)): **Balant Funding arrangement (check all that apply) **Plan fun	6 Total number of participants at the beginning of the plan year	· 6 ·	1601
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C Other retired or separated participants entitled to future benefits d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits e Page 36 f Total. Add lines 7d and 7e g Number of participants with account balances as of the end of the plan year (only defined contribution plans g complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less h 14 than 100% vested i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated i 11 participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) a ☑ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)): b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan funding arrangement (check all that apply) 1) ☐ Insurance (2) ☐ Section 412(e)(3) insurance contracts (3) ☐ Trust (4) ☐ General assets of the sponsor 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.) a Pension Benefit Schedules b Financial Schedules 1 (Financial Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (3) ☐ B (Actuarial Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (3) ☐ B (Actuarial Information)			
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(4) E (ESOP Annual Information)	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (6) D (DFE/Participating Plan Information Schedules		
	(3) B (Actuarial Information)		



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to **Public Inspection**

			l entries in acco actions to the Fo		
	Identification Information ar 2008 or fiscal plan yea	1			
A This return/report is for:	(1) a multiemployer pla (2) a single-employer p employer plan);	an;		(3) a multiple-employer pla (4) a DFE (specify)	n;
B This return/report is:	(1) the first return/repo (2) the amended return		an;	(3) ☐ the final return/report fil (4) ☐ a short plan year return months).	
C If the plan is a collective	ely-bargained plan, check h	iere 🗌			
Part II Basic Plan Info 1a Name of plan	sion of time to file, check th ormation – enter all reques ELECTRICAL CONTRACT	sted information		extension application ☑ 1b Three-digit plan number (PN 1c Effective date of February 01, 19	plan (mo., day, yr.)
(Address should includ	ECTRICAL CONTRACT OF		, , ,	·	cation Number (EIN)
Under penalties of perjury	and other penalties set fort	h in the instruct	ions, I declare th	ed unless reasonable cause is es lat I have examined this return/re dge and belief, it is true, correct,	port, including
				(^TVV,	
Signature of p	lan administrator	Date	Typed or print	ed name of individual signing as	plan administrator
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or pri	nted name of individual signing a sponsor or DFE as applicable	
For Paperwork Reduction v11.3	n Act Notice and OMB Co	ntrol Numbers	, see the instru	ctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's nar	ne and address (if same as	s plan sponsor,	enter"Same")	3b Administrator 3c Administrator	's EIN 's telephone number
SA14M				•	
	f the plan sponsor has char number from the last return.		ast return/report	filed for this plan, enter the	b EIN
a Sponsor's name					c PN

Instant 189 FGBERI 1900 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit Q_{0} of 2 Objectors Form 5500s Pg 19 of 43

5	Preparer information (optional) a Name (including firm name, if applicable) and address	I	b EIN 23-2932984
	PARRNTEBEAFT) LLC THOMAS E. RILEY 115 SOT-AR SMEET 100 S'YKACUSE M 13204	. (Telephone no. 154712777
6	Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 ·	1180
	Active participants	а	874
	Retired or separated participants receiving benefits	. b .	281
	Other retired or separated participants entitled to future benefits		201
	Subtotal. Add lines 7a , 7b , and 7c	۲, C	1155
		d	1100
	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	e	
	Total. Add lines 7d and 7e	f	
	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	i	
8	Benefits provided under the plan (complete 8a through 8c, as applicable)		
а	Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat	ure c	odes from the List
	of Plan Characteristics Codes (printed in the instructions)):		
b	Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature Plan Characteristics Codes (printed in the instructions)):	e cod	es from the List of
9a	Plan funding arrangement (check all that apply) (1)		
	(4) General assets of the sponsor (4) General assets of the sponsor		
10	Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructi	ions.)	
a	Pension Benefit Schedules b Financial Schedules	,	
	(1) R (Retirement Plan Information) (1) X H (Financial Information)		
	(2) I (Financial Information – Small Pla	ın)	
	(2) 🔲 OT (Qualified Pension Plan Coverage Information) (3) 🗵 0 A (Insurance Information)	,	
	(4) X C (Service Provider Information)		
	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (5) X D (DFE/Participating Plan Information G (Financial Transaction Schedules)		
	(3) B (Actuarial Information)		
	(4) E (ESOP Annual Information)		
	(5) SSA (Separated Vested participant Information)		
	() () () () () () () () () ()		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

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OMB Nos. 1210 - 0110
1210 - 0089
2008

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This Form is Open to Public Inspection

		Complete al	l entries in according to the Fo	rdance with	
	ldentification Information ar 2008 or fiscal plan year	l			
A This return/report is			11e 01, 2000 , and		.1
for:	(1) a multiemployer pla(2) a single-employer p employer plan);		a multiple-	(3) ☐ a multiple-employer p (4) ☐ a DFE (specify)	oian;
B This return/report is:	(1) ☐ the first return/repor (2) ☐ the amended return	t filed for the pl /report;	an;	(3) ☐ the final return/report (4) ☐ a short plan year retumonths).	filed for the plan; irn/report (less than 12
C If the plan is a collective	ely-bargained plan, check h	ere 🗵			
D If you filed for an extens	sion of time to file, check the	e box and attac	h a copy of the ex	xtension application 🗵	
•	ormation - enter all reques				
1a Name of plan			•	1b Three-digit plan number (PN) 501
IBEW LOCAL 241 WEL	FARE BENEFITS PLAN			1c Effective date January 01, 19	of plan (mo., day, yr.) 960
2a Plan sponsor's name at (Address should include	nd address (employer, if for e room or suite no.)	a single-emplo	yer plan)	15-0347948	tification Number (EIN)
IREMAI OCAL 244				2c Sponsor's tele	phone number
IBEW LOCAL 241 701 W. STATE STREE ITHACA NY 14850-330				607-272-2809 2d Business code 238210	(see instructions)
Under penalties of perjury accompanying schedules,	and other penalties set forth	n in the instruct	ions, I declare that est of my knowled	d unless reasonable cause is at I have examined this return, dge and belief, it is true, corrected and belief are true, corrected and true, corrected are true, corrected and true, corrected and true, corrected are true, corrected a	/report, including ct, and complete.
Signature of employ	yer/plan sponsor/D F E	Date	Typed or prin	ted name of individual signing sponsor or DFE as applica	
For Paperwork Reduction v11.3	n Act Notice and OMB Cor	ntrol Numbers	, see the instruc	tions for Form 5500.	Form 5500 (2008)
3a Plan administrator's nar	ne and address (if same as	plan sponsor,	enter"Same")	3b Administrati 15-034794	
SA14IE				3c Administrat	tor's telephone number
	the plan sponsor has chan		ast return/report f	filed for this plan, enter the	b EIN
a Sponsor's name	number from the last return/	report below:			c PN

Instable 01-789 for ERISAC 4070-6 Filed 05/16/11 Entered 05/16/11 15:43:49 Exhibit \bigcirc of 2 Objectors Form 5500s Pg 21 of 43

5 Preparer information (optional) a Name (including firm name, if applicable) and address		b EIN 16-1171627
CDT.14 & COMPANY CPAR, LLP PA!RXIC'K JORNAN 401 E STATE ST SITE 5DO ITHARA 14850	•	c Telephone no. 607-272-4444
 Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) 	· 6 ·	166
a Active participantsb Retired or separated participants receiving benefits	a · b ·	200
c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	c d e	200
f Total. Add lines 7d and 7e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	f g	
 h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated 	h i	
participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension fe of Plan Characteristics Codes (printed in the instructions)):		codes from the List
b X Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feat Plan Characteristics Codes (printed in the instructions)):	ture cod	des from the List of
4A 4B 4D 4E 4L		
9a Plan funding arrangement (check all that apply) (1)	ıctions.))
(1) ☐ R (Retirement Plan Information) (1) ☒ H (Financial Information) (2) ☐ I (Financial Information – Small F (2) ☐ OT (Qualified Pension Plan Coverage Information) (3) ☒ 0 A (Insurance Information) (4) ☒ C (Service Provider Information)	,	
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year		
(3) B (Actuarial Information) (4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

This Form is Open to **Public Inspection**

		Complete al	nue Code (the Il entries in acc actions to the F	cordance with	
	Identification Information				
•	ar 2008 or fiscal plan yea		ily 01, 2008 , ar		
A This return/report is for:	(1) Ϫ a multiemployer pla (2) ☐ a single-employer plan);		a multiple-	(3)	an;
B This return/report is:	(1) ☐ the first return/repo (2) ☐ the amended return		lan;	 (3) ☐ the final return/report f (4) ☐ a short plan year returmonths). 	
C If the plan is a collective	ely-bargained plan, check h	nere 🗵		·	
D If you filed for an exten	sion of time to file, check th	e box and attac	ch a copy of the	extension application	
Part II Basic Plan Inf	ormation - enter all reques	sted information	i.		
1a Name of plan	EALTH O MELEADE EUNI	_		1b Three-digit plan number (F	
1.B.E.W. LOCAL 910 H	EALTH & WELFARE FUNI	J		• 1c Effective date of January 01, 19	of plan (mo., day, yr.) 66
2a Plan sponsor's name a (Address should includ	nd address (employer, if fo e room or suite no.)	r a single-emplo	oyer plan)	2b Employer Ident 16-6053626	ification Number (EIN)
1 D E M 1 O C M 1 O 1 O 1		<u> </u>		2c Sponsor's telep	hone number
25001 WATER STREE	EALTH & WELFARE FUNI T	J		315-782-5941 • 2d Business code	(see instructions)
WATERTOWN NY 136	01-2145			561110	(occ mon denome)
Under penalties of perjury	and other penalties set fort	h in the instruct	tions, I declare t	sed unless reasonable cause is e that I have examined this return/r ledge and belief, it is true, correc	eport, including
		•	•	JAN F LLIC-	
Signature of p	lan administrator	Date	Typed or prir	nted name of individual signing a	s plan administrator
				JDME^ 14 JX),-AKR15	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or pr	rinted name of individual signing sponsor or DFE as applicab	
For Paperwork Reduction v11.3	n Act Notice and OMB Co	ntrol Numbers	s, see the instru	uctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's na	me and address (if same as	s plan sponsor,	enter"Same")	3b Administrato 16-6053626	
TRUSTEES OF THE I.I 25001 WATER STREE WATERTOWN NY 136		H & WELFARE	FUND		or's telephone number 5-782-5941
4 If the name and/or EIN o		nged since the l	last return/repor	rt filed for this plan, enter the	b EIN
					c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address b b	EIN
· c ¬	elephone no.
6 Total number of participants at the beginning of the plan year 7 Number of participants at the beginning of the plan year	512
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) a Active participants a	539
a Active participants b Retired or separated participants receiving benefits b · b	69
c Other retired or separated participants entitled to future benefits	00
d Subtotal. Add lines 7a, 7b, and 7c d	608
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits e	
f Total. Add lines 7d and 7e	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans g complete this item)	
h Number of participants that terminated employment during the plan year with accrued benefits that were less h than 100% vested	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)	
a <u>Pension benefits</u> (check this box if the plan provides pension benefits and enter the applicable pension feature cod of Plan Characteristics Codes (printed in the instructions)):	es from the List
b 🔀 <u>Welfare benefits</u> (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes Plan Characteristics Codes (printed in the instructions)):	from the List of
<u>4U</u>	
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)	
(1) Insurance (1) Insurance	
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts	
(3) Trust (3) Trust	
(4) General assets of the sponsor (4) General assets of the sponsor	
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)	
a Pension Benefit Schedules b Financial Schedules (4) H (Financial Information)	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) I (Financial Information – Small Plan)	
(2) OT (Qualified Pension Plan Coverage Information) (3) 3 A (Insurance Information)	
(4) X C (Service Provider Information)	
If a Schedule T is not attached because the plan is (5) D (DFE/Participating Plan Information)	
relying on coverage testing information for a prior (6) 📙 G (Financial Transaction Schedules)	
year, enter the year	
<u></u>	
(3) B (Actuarial Information) (4) E (ESOP Annual Information)	



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

This Form is Open to **Public Inspection**

Revenue Code (the Code).

		Complete a	II entries in acco actions to the Fo	ordance with orm 5500.	
	: Identification Information				
For the calendar plan ye	ar 2008 or fiscal plan year	beginning Ja	nuary 01, 2008,	and ending December 31, 200	08
A This return/report is for:	 (1)		a multiple-	(3) ☐ a multiple-employer pla (4) ☐ a DFE (specify)	in;
B This return/report is:	(1) the first return/report (2) the amended return/		lan;	(3) the final return/report fil (4) a short plan year return months).	
C If the plan is a collective	ely-bargained plan, check he	ere 🗓		·	
Part II Basic Plan Inf	sion of time to file, check the ormation – enter all request				
1a Name of plan LABORERS LOCAL 10	03 ANNUITY FUND			1b Three-digit plan number (PN 1c Effective date of June 01, 2002	
2a Plan sponsor's name a (Address should includ	nd address (employer, if for e room or suite no.)	a single-emplo	oyer plan)	2b Employer Identif 01-6214544 2c Sponsor's teleph	ication Number (EIN)
TRUSTEES OF LABO P.O. BOX 571 GENEVA NY 14456-05	RERS LOCAL 103 ANNUITY	Y FUND		315-539-4220 2d Business code (s 525100	
Under penalties of perjury	and other penalties set forth	in the instruc	tions, I declare th	ed unless reasonable cause is es at I have examined this return/re dge and belief, it is true, correct,	port, including
				UNION TRUSTEE	
Signature of p	olan administrator	Date	Typed or print	ed name of individual signing as	plan administrator
				MANAGEMENT TRUSTEE	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or prin	nted name of individual signing a sponsor or DFE as applicable	
For Paperwork Reduction v11.3	n Act Notice and OMB Cor	ntrol Numbers	s, see the instruc	ctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's na	me and address (if same as	plan sponsor,	enter"Same")	3b Administrator	's EIN 's telephone number
SAIME				, sc Administrator	s rereprione number
	f the plan sponsor has chan number from the last return/i		last return/report	filed for this plan, enter the	b EIN
a Sponsor's name					c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EII	N
	· c Tel	lephone no.
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 ·	166
 a Active participants b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits 	a · b · c	159
 d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits 	d e	159
 f Total. Add lines 7d and 7e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) 	f g	159 159
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature of Plan Characteristics Codes (printed in the instructions)): 	i ure codes	from the List
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature Plan Characteristics Codes (printed in the instructions)):	e codes fr	om the List of
9a Plan funding arrangement (check all that apply) (1)	n) ·n)	



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

a Sponsor's name

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

Revenue Code (the Code).
Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This Form is Open to Public Inspection

			actions to the i	-0111 5500.		
	: Identification Information ear 2008 or fiscal plan year		nuary 01, 2008	, and ending December 31, 2	008	
A This return/report is for:	 (1) ∑ a multiemployer pla (2) ☐ a single-employer pemployer plan); 		a multiple-	(3) ☐ a multiple-employer p (4) ☐ a DFE (specify)	olan;	
B This return/report is:	(1) ☐ the first return/repor (2) ☐ the amended return		lan;	(3) ☐ the final return/report(4) ☐ a short plan year retumonths).		
C If the plan is a collective	ely-bargained plan, check h	ere 🛚		,.		
•	sion of time to file, check the			extension application 🗵		
1a Name of plan	ormation - enter an reques	ica imormation	·•	1b Three-digit	. 501	
LABORERS LOCAL 10	03 WELFARE FUND			plan number (1c Effective date October 15, 1	of plan (mo., day, yr.)	
2a Plan sponsor's name a (Address should includ	nd address (employer, if for e room or suite no.)	a single-emplo	oyer plan)	16-0778602	tification Number (EIN)	
TRUSTEES OF LABOR	RERS LOCAL 103 WELFAF	RE FUND		2c Sponsor's telephone number 315-539-4220		
P.O. BOX 571 GENEVA NY 14456-05	371			2d Business code 525100	e (see instructions)	
Under penalties of perjury	and other penalties set forth	n in the instruc	tions, I declare t	sed unless reasonable cause is that I have examined this return edge and belief, it is true, corre	/report, including	
				UNION TRUSTEE		
Signature of p	lan administrator	Date	Typed or pri	nted name of individual signing	as plan administrator	
				MANAGEMENT TRUSTE	Ε	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or p	rinted name of individual signing sponsor or DFE as applica	g as employer, plan ble	
For Paperwork Reduction v11.3	n Act Notice and OMB Co	ntrol Numbers	s, see the instr	uctions for Form 5500.	Form 5500 (2008)	
	me and address (if same as	plan sponsor,	enter"Same")	3b Administra	tor's EIN tor's telephone number	
SAIMP					Transpire	
	f the plan sponsor has chan number from the last return/		last return/repo	rt filed for this plan, enter the	b EIN	

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN
	c Telephone no.
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	. 169
a Active participants	82
b Retired or separated participants receiving benefits	
c Other retired or separated participants entitled to future benefits	57
d Subtotal. Add lines 7a, 7b, and 7c	147
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	
f Total. Add lines 7d and 7e f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	
h Number of participants that terminated employment during the plan year with accrued benefits that were less h than 100% vested	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)	
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature of Plan Characteristics Codes (printed in the instructions)):	codes from the List
b X Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature of Plan Characteristics Codes (printed in the instructions)): 4A 4C 4D 4E 4L 4Q	odes from the List o
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)	
(1) Insurance (1) Insurance	
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts	
(3) Trust	
(4) General assets of the sponsor (4) General assets of the sponsor	,
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions a Pension Benefit Schedules b Financial Schedules	;.)
(1) R (Retirement Plan Information) (1) X H (Financial Information)	
(2) I (Financial Information – Small Plan)	
(2) OT (Qualified Pension Plan Coverage Information) (3) O A (Insurance Information)	
(4) 🗵 C (Service Provider Information)	
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year	
(3) B (Actuarial Information)	
(4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information)	



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

NWMGO NY 13126

Annual Return/Report of **Employee Benefit Plan**

This form is required to be filed under sections 104 and 4065 of the This Form is Open to Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

Revenue Code (the Code). Complete all entries in accordance with

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Public Inspection

· 2d Business code (see instructions)

525100

he plan; (less than 12
004
no., day, yr.)
Number (EIN)
mber
00 no., day Number

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	10/11/2109	CINVY	RA.C;TAT.T)O	
Signature of plan administrator	Date	Typed or printed name of individual signing as plan admini		
)SWEGO T.AF30RI	KKS LORAY, 214 I	RETIRK
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of in sponsor or l	dividual signing as D F E as applicable	employer, plan
For Paperwork Reduction Act Notice and OMB Con v11.3	ntrol Numbers,	see the instructions for Forn	n 5500.	Form 5500 (2008)
3a Plan administrator's name and address (if same as plan sponsor, e		enter"Same") 3b Administrator's EIN 16-0876163		
SA14IE : 3c Administrator's				telephone number
4 If the name and/or EIN of the plan sponsor has chang name, EIN and the plan number from the last return/r		st return/report filed for this pla	n, enter the	b EIN
a Sponsor's name				c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b	EIN 23-3060766
BRAPN MILLKK COMPANY LLP TH014AS E RIT.JSY 115 SOT-AR S'RK(RET 100 S)RMACUSE 13204	· c	Telephone no. 315-471-2777
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 ·	504
a Active participants	а	103
b Retired or separated participants receiving benefits	·b·	269
c Other retired or separated participants entitled to future benefits	С	96
d Subtotal. Add lines 7a, 7b, and 7c	d	468
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	е	36
f Total. Add lines 7d and 7e	f	504
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 	i	11
8 Benefits provided under the plan (complete 8a through 8c, as applicable)		
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension fea of Plan Characteristics Codes (printed in the instructions)):	ture co	des from the List
<u>1B</u> <u>1G</u>		
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare featu	re code	es from the List of
Plan Characteristics Codes (printed in the instructions)):		
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)		
(1) Insurance (1) Insurance		
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
(3) Trust		
(4) General assets of the sponsor (4) General assets of the sponsor		
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruct	tions.)	
a Pension Benefit Schedules b Financial Schedules		
(1) X R (Retirement Plan Information) (1) X H (Financial Information)	>	
(2) I (Financial Information – Small Plate (2) I (Qualified Pension Plan Coverage Information) (3) I (Financial Information)	an)	
(4) X C (Service Provider Information)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (4) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (5) X D (DFE/Participating Plan Information) G (Financial Transaction Schedules)		
year, enter the year	•	
(3) B (Actuarial Information)		
(4) E (ESOP Annual Information)		
(5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor **Employee Benefits Security** Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

Official Use Only OMB Nos. 1210 - 0110 1210 - 0089 2008

Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

This Form is Open to **Public Inspection**

Complete all entries in accordance with

		the instr	uctions to the F	orm 5500.		
	t Identification Information				D	20
•	ear 2008 or fiscal plan year	-	inuary 01, 2008			
A This return/report is for:	 (1)		a multiple-	(3) ∐ a mu (4) ☐ a DF	Itiple-employer pla E (specify)	an;
B This return/report is:	(1) the first return/repor (2) the amended return		lan;		nal return/report fi ort plan year returr	led for the plan; n/report (less than 12
C If the plan is a collective	ely-bargained plan, check h	ere 🗓				
_	sion of time to file, check the		ch a copy of the	extension appli	ication 🗌	
•	ormation - enter all reques			женен арри		
1a Name of plan	, ,			11	Three-digit	. 501
PLUMBERS PIPE FIT	TERS & APPRENTICES LO	CAL 112 HEA	LTH PLAN		plan number (Pl Effective date of October 01, 196	v) f plan (mo., day, yr.)
2a Plan sponsor's name a (Address should includ	and address (employer, if for le room or suite no.)	a single-empl	oyer plan)	21:	Employer Identii 16-6053348	ication Number (EIN
TRUSTEES OF PLUM 11 GRISWOLD STREE BINGHAMTON NY 139		PRENTICES I	.OCAL 112 HEAI	-TH FUND _.	 Sponsor's teleph 607-722-1883 Business code (238220 	
Under penalties of perjury	elate or incomplete filing of t and other penalties set forth statements and attachment	in the instruc	tions, I declare th	at I have exan	nined this return/re	eport, including
				UNIC	ON TRUSTEE	
Signature of p	olan administrator	Date	Typed or print	ed name of in	dividual signing as	plan administrator
				EMPLC	YER TRUSTEE	
Signature of emplo	yer/plan sponsor/DFE	Date	Typed or pri		ndividual signing a DFE as applicabl	
For Paperwork Reductio v11.3	n Act Notice and OMB Cor	ntrol Numbers	s, see the instru	ctions for For	m 5500.	Form 5500 (2008)
3a Plan administrator's na	me and address (if same as	plan sponsor,	enter"Same")		3b Administrato 3c Administrato	r's EIN r's telephone number
4 If the name and/or EIN o name, EIN and the plan	of the plan sponsor has chan number from the last return/	ged since the	last return/report	filed for this pl	lan, enter the	b EIN
a Sponsor's name		, ,				c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b	EIN
	. c	Telephone no.
 Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) 	· 6 ·	686
a Active participants	а	413
b Retired or separated participants receiving benefits	· b ·	229
c Other retired or separated participants entitled to future benefits	С	
d Subtotal. Add lines 7a, 7b, and 7c	d	642
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	е	
f Total. Add lines 7d and 7e	f	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 	i	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)		
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension fear of Plan Characteristics Codes (printed in the instructions)):	ture cod	les from the List
b X Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature. Plan Characteristics Codes (printed in the instructions)):	re code:	s from the List o
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply)	-	
(1) Insurance (Check all that apply)		
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
(2) Section 412(e)(5) insurance contracts (2) Section 412(e)(5) insurance contracts (3) Trust		
(4) ☐ General assets of the sponsor (4) ☐ General assets of the sponsor 10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruct	tiona)	
a Pension Benefit Schedules boxes and, where indicated, effect the number attached. See instruction by Financial Schedules	.10115.)	
(1) R (Retirement Plan Information) (1) X H (Financial Information)		
(2) I (Financial Information – Small Pla	an)	
(2) OT (Qualified Pension Plan Coverage Information) (3) 🗵 0 A (Insurance Information)	,	
(4) 🔣 C (Service Provider Information)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (5) D (DFE/Participating Plan Information G) (6) G (Financial Transaction Schedules		
year, enter the year		
(3) B (Actuarial Information)		
(4) E (ESOP Annual Information)		
(5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

This Form is Open to Public Inspection

•		tne instru	ictions to the Fo	rm 5500.		
	Identification Information					
•	ear 2008 or fiscal plan year		ly 01, 2008, and			
A This return/report is for:	 (1)		a multiple-	(3) ☐ a multiple-employer pla (4) ☐ a DFE (specify)	n;	
B This return/report is:	(1) the first return/report (2) the amended return.		an;	(3) the final return/report fil (4) a short plan year return months).		
C If the plan is a collective	ely-bargained plan, check he	ere 🗶		,		
	ision of time to file, check the		h a copy of the e	xtension application 🗵		
	ormation - enter all request					
1a Name of plan				1b Three-digit plan number (PN		
ROOFERS LOCAL 19	1c Effective date of July 01, 1449	plan (mo., day, yr.)				
2a Plan sponsor's name a (Address should includ	and address (employer, if for le room or suite no.)	a single-emplo	oyer plan)	2b Employer Identifi 14-1721374	,	
ROOFERS LOCAL 19	5 ANNUITY FUND			2c Sponsor's telephone number 315-699-1388		
6200 STATE ROUTE 3 CICERO NY 13039-88	31			2d Business code (see instructions) 525100		
Under penalties of perjury	and other penalties set forth	in the instruct	ions, I declare tha	d unless reasonable cause is es at I have examined this return/re dge and belief, it is true, correct,	port, including	
				RL (C/ ^Q NO		
Signature of p	olan administrator	Date	Typed or printe	ed name of individual signing as	plan administrator	
•			•			
Signature of emplo	oyer/plan sponsor/D F E	Date	Typed or prir	nted name of individual signing a sponsor or DFE as applicable		
For Paperwork Reductio v11.3	n Act Notice and OMB Cor	ntrol Numbers	, see the instruc		Form 5500 (2008)	
3a Plan administrator's na	me and address (if same as	plan sponsor,	enter"Same")	3b Administrator 3c Administrator	's EIN 's telephone number	

name, EIN and the plan number from the last return/report below:

a Sponsor's name

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	I	b EIN 23-2932984
PARENTEBRARD LLC THOMAS E. RILEY 115 SOT-AR SRXEET 100 SYMACLISE 13204		c Telephone no. 154712777
 Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) 	· 6 ·	327
a Active participants	а	228
b Retired or separated participants receiving benefits	·b·	17
c Other retired or separated participants entitled to future benefits	С	113
d Subtotal. Add lines 7a, 7b, and 7c	d	358
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	е	2
f Total. Add lines 7d and 7e	f	360
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	13
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 	i	16
8 Benefits provided under the plan (complete 8a through 8c, as applicable)		
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat of Plan Characteristics Codes (printed in the instructions)):	ture c	odes from the List
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature Plan Characteristics Codes (printed in the instructions)):	re cod	 les from the List of
On Diagram of the second control of the second of the seco		
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check all that apply) (1) ☐ Insurance (1) ☐ Insurance		
(1) Insurance (2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts		
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insurance contracts (3) Trust		
(4) General assets of the sponsor (4) General assets of the sponsor		
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instruct	tions)	
a Pension Benefit Schedules b Financial Schedules	,	
(1) R (Retirement Plan Information) (1) X H (Financial Information)	>	
(2) UT (Qualified Pension Plan Coverage Information) (3) I (Financial Information – Small Plate (2) UT (Qualified Pension Plan Coverage Information)	an)	
(4) C (Service Provider Information) If a Schedule T is not attached because the plan is (5) D (DFE/Participating Plan Information)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year		
(3) B (Actuarial Information)		
(4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information)		
(e) [mail of the Company of the Comp		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

Revenue Code (the Code).
Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This Form is Open to

Public Inspection

Part I Annual Report Identification Information For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009 A This return/report is (1) X a multiemployer plan; (3) a multiple-employer plan; for: (2) a single-employer plan (other than a multiple-(4) a DFE (specify) employer plan); B This return/report is: (1) \square the first return/report filed for the plan; (3) the final return/report filed for the plan; (2) the amended return/report; (4) a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check here D If you filed for an extension of time to file, check the box and attach a copy of the extension application 🗵 Part II - Basic Plan Information - enter all requested information. 1a Name of plan 1b Three-digit 501 plan number (PN) ROOFERS LOCAL 195 HEALTH & ACCIDENT FUND 1c Effective date of plan (mo., day, yr.) July 01, 1972 2a Plan sponsor's name and address (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) (Address should include room or suite no.) 16-6148181 2c Sponsor's telephone number **ROOFERS LOCAL 195 HEALTH & ACCIDENT FUND** 315-699-1388 6200 STATE ROUTE 31 2d Business code (see instructions) CICERO NY 13039-8804 525100 Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete. Signature of plan administrator Date Typed or printed name of individual signing as plan administrator Typed or printed name of individual signing as employer, plan Signature of employer/plan sponsor/DFE Date sponsor or DFE as applicable For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. Form 5500 (2008) 3a Plan administrator's name and address (if same as plan sponsor, enter"Same") 3b Administrator's EIN 3c Administrator's telephone number SAME 4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the b EIN

name, EIN and the plan number from the last return/report below:

a Sponsor's name

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address		b EIN 23-2932984	
PARENTEBEARD LLC THOMAS E. RILEY 115 SOLAR STREET 100 SYRACUSE 13204		c Telephone no. 315-471-2777	
 Total number of participants at the beginning of the plan year Number of participants as of the end of the plan year (welfare plans complete only lines 7a 		· 6 · 184	
a Active participants		a 210	
b Retired or separated participants receiving benefitsc Other retired or separated participants entitled to future benefits	•	· b ·	
d Subtotal. Add lines 7a, 7b, and 7c		d 210	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		e	
f Total. Add lines 7d and 7e		f	
g Number of participants with account balances as of the end of the plan year (only defined complete this item)	contribution plans	g	
h Number of participants that terminated employment during the plan year with accrued beneathan 100% vested	efits that were less	h	
i If any participant(s) separated from service with a deferred vested benefit, enter the number participants required to be reported on a Schedule SSA (Form 5500)	er of separated	i	
Benefits provided under the plan (complete 8a through 8c, as applicable)			
a Pension benefits (check this box if the plan provides pension benefits and enter the ap of Plan Characteristics Codes (printed in the instructions)):	pplicable pension featu	ire codes from the Lis	ŧt
b Welfare benefits (check this box if the plan provides welfare benefits and enter the app Plan Characteristics Codes (printed in the instructions)):	olicable welfare feature	ecodes from the List o	of
<u>4A</u> 4B			
9a Plan funding arrangement (check all that apply) 9b Plan benefit arrangement (check (1) Insurance (1) Insurance			
(2) Section 412(e)(3) insurance contracts (2) Section 412(e)(3) insura (3) Trust (3)			
(4) General assets of the sponsor (4) General assets of the sp	onsor		
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number a	ttached. See instruction	ons.)	
a Pension Benefit Schedules (1) ☐ R (Retirement Plan Information) b Financial Schedules (1) ☒ H (Financial Information)	formation)		
	formation – Small Plar	n)	
	nformation) vider Information)		
If a Schedule T is not attached because the plan is . (5) X D (DFE/Partici	pating Plan Informatio ansaction Schedules)		
 (3) B (Actuarial Information) (4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information) 			



Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

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1210 - 0089
2008

Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal

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Pension Benefit Guaranty	Corporation sectio	Reve Complete al	e), 6057(b), and nue Code (the C Il entries in acco uctions to the Fo	rdance with	
Part I Annual Report		on			
•			nuary 01, 2008,	and ending December 31, 200	
A This return/report is for:	(1) ☐ a multiemployer p (2) ☒ a single-employer employer plan);		a multiple-	(3) ☐ a multiple-employer pla (4) ☐ a DFE (specify)	n;
B This return/report is:	(1) ☐ the first return/rep (2) ☐ the amended retu		lan;	(3) ☐ the final return/report fil (4) ☐ a short plan year return months).	
C If the plan is a collective	ely-bargained plan, check	here 🗌			
D If you filed for an extens Part II Basic Plan Info	sion of time to file, check	the box and attac	· •	xtension application	
1a Name of plan	omor an roqu		•	1b Three-digit	
·				plan number (PN	
SYRACUSE BUILDER:	S EXCHANGE, INC. / CE	A PENSION PLA	/N	1c Effective date of January 01, 198	plan (mo., day, yr.) 2
2a Plan sponsor's name as (Address should include		for a single-emplo	oyer plan)	2b Employer Identifi 15-0464360	
0,000,01100,01111,000	C EVOLIANCE INC			2c Sponsor's teleph	one number
SYRACUSE BUILDERS 6563 RIDINGS ROAD SYRACUSE NY 13206	•			315-437-9936 • 2d Business code (s 238900	see instructions)
Under penalties of perjury	and other penalties set fo	orth in the instruct	tions, I declare tha	d unless reasonable cause is es at I have examined this return/re dge and belief, it is true, correct,	port, including
				EARL N. HALL	
Signature of p	lan administrator	Date	Typed or printe	ed name of individual signing as	plan administrator
				EARL N. HALL	
Signature of employ	yer/plan sponsor/DFE	Date	Typed or prir	nted name of individual signing a sponsor or DFE as applicable	
For Paperwork Reduction v11.3				ctions for Form 5500.	Form 5500 (2008)
3a Plan administrator's nar	ne and address (if same	as plan sponsor,	enter"Same")	3b Administrator	's EIN 's telephone number
SAME					2 -2-epitono mambol
4 If the name and/or EIN of name, EIN and the plan r			last return/report	filed for this plan, enter the	b EIN
a Sponsor's name					c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN		
	· c	Telephone no.	
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 ·	14	
 a Active participants b Retired or separated participants receiving benefits 	a ·b·	15	
 c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 7d and 7e 	c d e f	15 15	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	g	15	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h		
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat of Plan Characteristics Codes (printed in the instructions)): 	i ture co	odes from the List	
<u>2E</u> <u>2J</u>			
b Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature Plan Characteristics Codes (printed in the instructions)):	re cod	es from the List of	
9a Plan funding arrangement (check all that apply) (1)	an) on)		



Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2007

Pension Benefit Guaranty Corporation

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

This Form is Open to Public Inspection

the instructions to the Form 5500. Part I Annual Report Identification Information For the calendar plan year 2007 or fiscal plan year beginning November 01, 2007, and ending October 31, 2008 A This return/report is (1) X a multiemployer plan; (3) a multiple-employer plan; for: (2) a single-employer plan (other than a multiple-(4) a DFE (specify) employer plan); B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan; (2) the amended return/report; (4) a short plan year return/report (less than 12 months). C If the plan is a collectively-bargained plan, check here D If you filed for an extension of time to file, check the box and attach a copy of the extension application 🗵 Part II Basic Plan Information - enter all requested information. 1a Name of plan 1b Three-digit 501 plan number (PN) SERVICE EMPLOYEES BENEFIT FUND 1c Effective date of plan (mo., day, yr.) January 01, 1965 2a Plan sponsor's name and address (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) (Address should include room or suite no.) 15-0613682 2c Sponsor's telephone number SERVICE EMPLOYEES BENEFIT FUND 315-424-1754 1153 WEST FAYETTE STREET · 2d Business code (see instructions) SYRACUSE NY 13204-2741 525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

		TAMMY	A. MCMANUS	3
Signature of plan administrator	Date	Typed or printed name of ind	vidual signing	as plan administrator
		JEREMIA	H DENNIS, JF	₹.
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of in sponsor or l	dividual signin DFE as applica	
For Paperwork Reduction Act Notice and OMB Cor v2.3	ntrol Numbers	s, see the instructions for Forn	n 5500.	Form 5500 (2007)
3a Plan administrator's name and address (if same as plan sponsor, enter"Same")			3b Administrator's EIN	
SAME			3c Administra	tor's telephone number
If the name and/or EIN of the plan sponsor has chan name, EIN and the plan number from the last return/		last return/report filed for this pla	n, enter the	b EIN
a Sponsor's name				c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address	bΕ	IN
	. c Te	elephone no.
6 Total number of participants at the beginning of the plan year 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)	· 6 ·	12518
 a Active participants b Retired or separated participants receiving benefits 	a ·b·	12336 96
c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	c d e	12432
f Total. Add lines 7d and 7e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	f g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	h	
 i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) 	i	
a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feat of Plan Characteristics Codes (printed in the instructions)):	ure code	es from the List
b X Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature. Plan Characteristics Codes (printed in the instructions)):	e codes	from the List of
<u>4A 4D 4E 4F 4L</u>	**	** ***
9a Plan funding arrangement (check all that apply) (1)	ions.)	
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) I (Financial Information – Small Pla	ın)	
(2) OT (Qualified Pension Plan Coverage Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year (3) O A (Insurance Information) (4) C (Service Provider Information) D (DFE/Participating Plan Information) G (Financial Transaction Schedules)		
(3) B (Actuarial Information) (4) E (ESOP Annual Information) (5) SSA (Separated Vested participant Information)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan This form is required to be filed under sections 104 and 4065 of the

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1210 - 0089
2008

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This Form is Open to Public Inspection

Complete all entries in accordance with the instructions to the Form 5500.

Annual Report Identification Information

For the calendar plan y	ear 2008 or fiscal plan year	beginning Ja	nuary 01, 2008,	and ending December 31, 2	2008
A This return/report is for:	(1) X a multiemployer pla(2) a single-employer pemployer plan);	n; lan (other than	a multiple-	(3) ☐ a multiple-employer (4) ☐ a DFE (specify)	plan;
B This return/report is:	(1) ☐ the first return/repor (2) ☐ the amended return		lan;	(3) ☐ the final return/repor (4) ☐ a short plan year returnonths).	
C If the plan is a collective	vely-bargained plan, check h	ere 🗵			
D If you filed for an exter	nsion of time to file, check the	e box and attac	ch a copy of the e	extension application 🗵	
	formation - enter all reques	ted informati o n	•	4 5 TO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
1a Name of plan				1b Three-digit plan number	(PN) 001
SERVICE EMPLOYER	ES PENSION FD OF UPSTA	TE NEW YOR	K		of plan (mo., day, yr.)
2a Plan sponsor's name a (Address should include	and address (employer, if for de ro <mark>o</mark> m or suite no.)	a single-emplo	oyer plan)	2b Employer Ideo 16-0908576	ntification Number (EIN)
SERVICE EMPLOYE	ES PENSION FUND OF UPS	STATE NEW Y	ORK	2c Sponsor's tele 315-424-1754	
			•	d Business code (see instructions)	
accompanying schedules	, statements and attachment	s, and to the b	est of my knowle	dge and belief, it is true, corre -EL-1W RQOZC^^	ect, and complete.
		•		-LL-TVV NQOZO	
Signature of	plan administrat o r	Date	Typed or printe	ed name of individual signing	as plan administrator
Signature of empl	oyer/plan sponsor/DFE	Date	Typed or prir	nted name of individual signin sponsor or DFE as applica	
For Paperwork Reduction v11.3	on Act Notice and OMB Co	ntrol Numbers	s, see the instruc	ctions for Form 5500.	Form 5500 (2008)
	ame and address (if same as	plan sponsor,	enter"Same")	3b Administra 16-090857	
SERVICE EMPL PENS BETH BARRETT, FUN PO BOX 1240 SYRACUSE NY 1320		IEW YORK		3c Administra	ator's telephone number 315-424-1754
4 If the name and/or EIN	of the plan sponsor has chan number from the last return/	ged since the l	ast return/report	filed for this plan, enter the	b EIN
	and the state of t				c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address	b EIN	1
ROBERT E. KILFOYLE, CPA 109 S WARREN ST STE 1403 SYRACUSE NY 13202-4711		ephone no. 5-422-4900
6 Total number of participants at the beginning of the plan year	· 6 ·	7493
 7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d) a Active participants b Retired or separated participants receiving benefits c Other retired or separated participants entitled to future benefits d Subtotal. Add lines 7a, 7b, and 7c e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits f Total. Add lines 7d and 7e g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) h Number of participants that terminated employment during the plan year with accrued benefits that were less 	a b c d e f g	4942 1065 1791 7798 102 7900
 than 100% vested i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) 8 Benefits provided under the plan (complete 8a through 8c, as applicable) a Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature of Plan Characteristics Codes (printed in the instructions)): 	i ure codes	184 from the List
<u>1B</u>		~ · · · · ·
b <u>Welfare benefits</u> (check this box if the plan provides welfare benefits and enter the applicable welfare feature Plan Characteristics Codes (printed in the instructions)):	e codes fro	om the List o
9a Plan funding arrangement (check all that apply) (1)	·	
(2) OT (Qualified Pension Plan Coverage Information) (3) O A (Insurance Information) (4) C (Service Provider Information) If a Schedule T is not attached because the plan is relying on coverage testing information for a prior (5) D (DFE/Participating Plan Information) (6) G (Financial Transaction Schedules)		



Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

OSWJ5GO NY 13126-0911

Annual Return/Report of Employee Benefit Plan

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with

This Form is Open to Public Inspection

525100

the instructions to the Form 5500. Part I Annual Report Identification Information For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008 , and ending June 30, 2009 A This return/report is (1) X a multiemployer plan; (3) ☐ a multiple-employer plan; for: (2) a single-employer plan (other than a multiple-(4) a DFE (specify) employer plan); B This return/report is: (1) the first return/report filed for the plan; (3) the final return/report filed for the plan; (2) the amended return/report; (4) a short plan year return/report (less than 12) C If the plan is a collectively-bargained plan, check here D If you filed for an extension of time to file, check the box and attach a copy of the extension application 🗵 Part II - Basic Plan Information - enter all requested information. 1a Name of plan 1b Three-digit 001 plan number (PN) LOCAL 73 RETIREMENT FUND 1c Effective date of plan (mo., day, yr.) July 01, 1419 2a Plan sponsor's name and address (employer, if for a single-employer plan) 2b Employer Identification Number (EIN) (Address should include room or suite no.) 15-6016577 2c Sponsor's telephone number LOCAL 73 RETIREMENT FUND 315-343-1808 705 RAST SENECA STMEET, PO BOX 911 · 2d Business code (see instructions)

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

		JAIAKS	S GAFFNEY	
Signature of plan administrator	Date Typed or printed name of individual signing as plan			plan administrator
		LORAT. 73 RE	ETIR1914KNT FU	JNI)
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, places of sponsor or DFE as applicable		
For Paperwork Reduction Act Notice and OMB Con v11.3	trol Numbers	s, see the instructions for Form	1 5500.	Form 5500 (2008)
3a Plan administrator's name and address (if same as plan sponsor, enter"Same")		enter"Same")	3b Administrator's EIN 22-3739111	
JAMES GAFKNEY 705 EAST SENECA STREET PO BOX 911 OSWZGO NY 13126-0911		:: ·		r's telephone number 5-343-1808
4 If the name and/or EIN of the plan sponsor has chang name, EiN and the plan number from the last return/r		last return/report filed for this plan	n, enter the	b EIN
· ,	•			c PN

a Sponsor's name		
5 Preparer information (optional) a Name (including firm name, if applicable) PARENTEBEARN LLC THOMAS E. RILEY 115 SOLAR STREET 100	and address	b EIN 23-2932984 c Telephone no. 315-471-2777
SYRACUSE 13204		315-4/1-2///
6 Total number of participants at the beginning of the plan year	- 6	860
7 Number of participants as of the end of the plan year (welfare plans complet	e only lines 7a, 7b, 7c, and 7d)	
a Active participants	a	
b Retired or separated participants receiving benefits	· b	
c Other retired or separated participants entitled to future benefits	C	
d Subtotal. Add lines 7a, 7b, and 7c	d	
 e Deceased participants whose beneficiaries are receiving or are entitled to ref f Total. Add lines 7d and 7e 	eceive benefits e f	
g Number of participants with account balances as of the end of the plan year	-	
complete this item) h Number of participants that terminated employment during the plan year with	h accrued benefits that were less h	1
than 100% vested		
 i If any participant(s) separated from service with a deferred vested benefit, eleparticipants required to be reported on a Schedule SSA (Form 5500) 	nter the number of separated i	1
8 Benefits provided under the plan (complete 8a through 8c, as applicable)		
a X Pension benefits (check this box if the plan provides pension benefits ar of Plan Characteristics Codes (printed in the instructions)):	nd enter the applicable pension feature	codes from the List
	<u>1B</u>	
b Welfare benefits (check this box if the plan provides welfare benefits and Plan Characteristics Codes (printed in the instructions)):	d enter the applicable welfare feature of	codes from the List of
" //	ee ee ee ee	
9a Plan funding arrangement (check all that apply) 9b Plan benefit arran	ngement (check all that apply)	
(1) \square insurance (1) \square insurance		
(2) Section 412(e)(3) insurance contracts (2) Section 41 (3) Trust (3) Trust	12(e)(3) insurance contracts	
	ssets of the sponsor	
10 Schedules attached (Check all applicable boxes and, where indicated, enter	r the number attached. See instruction	s.)
a Pension Benefit Schedules b Financial	Schedules	
	H (Financial Information) I (Financial Information – Small Plan)	
(2) □0T (Qualified Pension Plan Coverage Information) (3) 🗵 1 A	A (Insurance Information) C (Service Provider Information)	
If a Schedule T is not attached because the plan is (5) X [D (DFE/Participating Plan Information)	
relying on coverage testing information for a prior (6) (6) (6) year, enter the year	G (Financial Transaction Schedules)	

(3) B (Actuarial Information)
(4) E (ESOP Annual Information)
(5) SSA (Separated Vested participant Information)